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Remote area nurses' experiences of workplace safety in very remote primary health clinics: A qualitative study

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Abstract

Aim: To explore Remote Area Nurses' experiences of the implementation of workplace health and safety policies and risk mitigation strategies in Australian very remote primary health clinics.

Design: This qualitative study used online semi-structured interviews, with participants purposively sampled to maximize variation in work location and service type. Data were analysed using a reflexive thematic analysis approach. Coding was carried out inductively, with NVivo 12 aiding data management.

Setting: The interviews were conducted from 24 Februrary 2021 to 06 March 2021 with Remote Area Nurses from very remote primary health clinics in Australia.

Participants: Fifteen Remote Area Nurses participated in the study.

Results: Thematic analysis revealed varied approaches to workplace safety among the different health services and regions. While the spread of 'never alone' policies in many clinics addressed one of the significant risks faced by Remote Area Nurses, gaps remained even for hazards specifically highlighted in existing work health and safety legislation. Meaningful collaboration with staff and the community, local orientation, preparation for the role and providing quality care were protective factors for staff safety. Understaffing, unsafe infrastructure and inadequate equipment were common concerns among Remote Area Nurses.

Conclusion: Health services need to prioritize workplace safety and take a continuous quality improvement approach to its implementation. This will include ensuring safety strategies are appropriate for the local context, improving infrastructure maintenance, and establishing sustainable second responder systems such as a pool of drivers with local knowledge.

Implications for the Profession: Poor personal safety contributes to burnout and high turnover of staff. Nurses' insights into the barriers and enablers of current workplace safety strategies will aid policymakers and employers in future improvements.

Reporting Method: COREQ reporting guidelines were followed.

PIPE Statement: A panel of six Remote Area Nurses collaborated in the development of this project.

KEYWORDS
Australia, occupational health and safety, remote area nursing, remote health workforce, risk management, safety management

1 | INTRODUCTION

From isolated tropical islands to small desert communities 700 km from the nearest hospital, Australia's healthcare system extends into incredibly remote settings. Although remote and very remote areas cover most of Australia's landmass, they have only 2% of the population (Australian Institute of Health and Welfare, 2022). This population is diverse, with 1 in 3 being Aboriginal or Torres Strait Islander. Remote Australians have a higher burden of disease, a higher rate of potentially preventable hospitalisations, and lower life expectancy than their metropolitan counterparts (Australian Institute of Health and Welfare, 2022).

In very remote areas, some larger towns have small hospitals with inpatient facilities, but most communities have primary health clinics (Lenthall et al., 2011). These clinics are usually open during office hours, with after-hours emergency care offered by on-call Remote Area Nurses (RANs) and Aboriginal and Torres Strait Islander Health Practitioners (ATSIHPs). The smallest settlements are outstations which usually have no permanent health service on-site. They are either serviced by visiting health professionals from the nearest clinic, or residents must travel to access care (Senior et al., 2018).

RANs are advanced-practice specialist-generalist nurses who are responsible for providing or facilitating remote healthcare, in collaboration with ATSIHPs (McCullough et al., 2022; National Health and Medical Research Council., 2002). However, recruitment and retention of RANs is notoriously difficult, with high-turnover rates leading to significant financial and quality of care costs (Russell et al., 2017). Poor Workplace Health & Safety (WHS) contributes to increased stress and anxiety among RANs and is linked to higher turnover (Kurti et al., 2012).

Several previous studies have explored WHS risks in remote health, particularly around workplace violence and RAN stress. Our scoping review found that poor organizational safety culture, workplace violence, lack of anonymity, unsafe infrastructure and insufficient orientation and preparation of new staff were all identified as significant WHS risks in remote health. Many recommendations were made to address these risks, but there was very little evidence of implementation and outcomes (Wright et al., 2021). The international literature further explores the issue of psychological safety in rural/remote nursing (Jahner et al., 2023; McKinless, 2020). The impact of traumatic events on rural nurses was found to be exacerbated by the blurred personal/professional boundaries that come with living and working in a rural/remote community and poor post-incident support from management (Jahner et al., 2023).

In 2016, the murder of RAN Gayle Woodford while on-call brought renewed calls for change around WHS in remote health. As a result, the Health Practitioner Regulation National Law (South Australia) (Remote Area Attendance) Amendment Act, ('Gayle's Law') was passed to improve call-out safety, and the other States and Territories are being urged to implement similar legislation (Aitken et al., 2021; Bowman, 2018; Parliament of South Australia, 2017). However, there is little evidence of the implementation, review or enforcement of other recommended safety strategies, such as having safe infrastructure and equipment, adequate preparation of staff for their role and good fatigue management (Wright et al., 2021).

To improve WHS in remote clinics, it is important to understand RANs' experiences with the implementation of those safety strategies. For example, what were the strengths, weaknesses, barriers, and enablers that caused the strategies to succeed or fail? To answer these questions, this article explores RANs' experiences of the implementation of WHS policies and risk mitigation strategies in very remote Australian primary health clinics.

2 | DESIGN

This is a qualitative study conducted as part of the lead author's thesis, which examines workplace health and safety for Remote Area Nurses in Australia (Wright, 2021).

2.1 | Study setting, participants, and data collection

Interview participants were selected from an anonymous online survey conducted in December 2020 and January 2021, which was open to RANs who had worked in a very remote (MM7) primary health clinic more recently than in January 2019, using the 2019 Modified Monash Model remoteness scale. Those who were nominated for an interview were grouped by state/territory and service type, then a random number generator was used to select interview participants. If no reply was received to the initial invitation email, a follow-up email was sent. Recruitment focussed on hearing the views of a diverse selection of RANs, rather than pursuing data saturation. Two participants withdrew before data collection took place, citing a lack of time. In total, 15 RANs participated in this study.

Ten questions were developed and pilot tested to guide the semi-structured interviews (see supplementary file). The questions were designed to spark discussion about what safety policies and strategies (either official or unofficial) were in place, their barriers and enablers, and participants' priorities for change. Interviews were conducted by the lead author via recorded Zoom meetings from 24 February 2021 to 06 May 2021. Technical difficulties were encountered twice but resolved by using a telephone connection.

Field notes were made, and interview recordings were transcribed verbatim. Transcripts were checked for accuracy while listening to the recordings, and then de-identified. Italics indicate where participants placed verbal emphasis on a word or phrase.

2.2 | Data analysis

Data were analysed using a reflexive thematic analysis approach (Braun & Clarke, 2021). This approach enabled the identification of patterns across the dataset while acknowledging researcher subjectivity inherent in qualitative research. Reflexivity was enhanced through a process of continual and critical self-evaluation undertaken to identify the lead author's positioning, background, and how it related to (and could potentially influence) participants and the interpretation of data (Berger, 2015).

Although the lead author is a Registered Nurse working in a remote area of the Northern Territory, she is not yet a RAN (an advanced specialist-generalist role). However, she was raised as the daughter of a RAN in remote Aboriginal communities, granting a neither insider nor outsider perspective of the role. The co-authors include a Registered Nurse and a social epidemiologist/demographer. Additionally, a group of experienced RANs collaborated on the development of the project, bringing their expertise from different regions and roles such as clinical, academic, education and management.

Research journaling formed an audit trail of the lead author's initial interpretations of the data and reflections on how her positionality shaped that interpretation and questioning. These reflections, the data and developing themes were discussed with the co-authors during data analysis to provide additional perspectives.

Coding was carried out inductively, with transcripts initially reviewed to build familiarity with the dataset. Subsequently, with NVivo 12 used to aid data management, the lead author coded each transcript. These codes were examined for broader patterns and meaning, and initial themes were developed. Themes were examined to see if they held when compared to the original data linked to the codes and the dataset. Finally, the themes were further refined, and the overall story told by each theme was developed. Reporting follows the COREQ guidelines (Tong et al., 2007).

2.3 | Ethics approval

Ethics approval to conduct this study was granted by the James Cook University Human Research Ethics Committee: H8255.

Informed consent was gained by emailing prospective participants the consent form and an information sheet detailing the study rationale, researcher's goals and data use. Interviews began with a reiteration of the study aim, the opportunity for questions, then confirmation of consent to participate.

This study provided a safe space for RANs to discuss systemic WHS issues. To protect participants' anonymity, transcripts were de-identified and health services were not named. No issues raised required mandatory reporting, and participants' confidentiality precluded the authors from reporting safety concerns to WHS regulators on their behalf.

3 | RESULTS

Fifteen RANs from six States/Territories participated in the interviews (see Table 1). The two male and 13 female participants were evenly distributed between short-term and long-term contracts, and between government-run and Aboriginal Community Controlled Health Organizations (ACCHOs). Length of experience as RANs ranged from 2 to 20+ years, with a median of 10 years of experience, while 27% ($n=4$) were recently a clinic manager.

The analysis identified three overarching themes: commitment to safety, knowledge and relationships and resources.

3.1 | Commitment to safety

The commitment to safety theme encompasses the organizational and workplace culture backdrop to the individual safety strategies.

TABLE 1 Interview participant characteristics ($N=15$).

Participant characteristics	*n* (%)
Region[a]	
Northern Territory	8 (53)
Queensland	3 (20)
Western Australia	2 (13)
South Australia	2 (13)
New South Wales	1 (7)
Indian Ocean Territory	1 (7)
Service type	
Government-run	6 (40)
ACCHO-run	6 (40)
Both	3 (20)
Contract type	
Long-term	5 (33)
Short-term	6 (40)
Both	4 (27)
Sex	
Female	13 (87)
Male	2 (13)
Clinic manager responsibilities	4 (27)
Length of RAN experience	
Range	2–20+ years
Median	10 years

[a]Where participants had worked in two regions within the previous few months, both were listed as their region of practice.

3.1.1 | Organizational approaches to WHS

Health services' approaches to WHS were described by participants as falling on a continuum, from not being on employers' radar at all, to a strong, proactive approach. Clinics without a safety policy framework left participants feeling at risk, either by enabling some staff or managers to undermine the unofficial strategies developed by the team or the perceived legal risk of not having official policies to back up their decisions. This is reflected by participant 2:

> It started after our colleague was [severely assaulted] - in terms of putting policies in place to ensure routine maintenance of all the [Qld region] health clinics. That seems to have crashed and - this is 10, 15 years down the track - it hasn't seemed to have found its feet yet.
>
> (Participant 2)

More commonly, participants reported that WHS was valued but not a very high priority in their health service. Some spoke of how WHS considerations took a back seat when faced with competing priorities such as the need to provide healthcare to patients, seasonal issues such as road closures, and efforts to protect the community from COVID-19.

Conversely, some participants experienced working for health services with a strong, proactive focus on WHS. These RANs found that a clear safety policy framework and supportive management were of key importance. Supportive management was said to include adequate resourcing and follow-up to ensure the safety strategies were implemented, as well as a willingness to receive and act on feedback from staff. "The bottom line was, if you felt unsafe, they would back you up for whatever you felt you needed to do to stay safe" (Participant 3). Some participants' employers made it clear from day one of orientation that staff safety was a priority, which was reinforced by the behaviour of management and their colleagues, creating a strong safety culture. "In terms of safety, this health service has policies and guidelines. It has enthusiastic implementation by the manager and the staff. And it has the resources to support the guidelines" (Participant 5).

3.1.2 | Tokenism

"If you can tick a box but you don't… *listen* and *hear* what's happening on the ground, you'll miss it, and it will happen again" (Participant 15).

Several participants spoke of a tokenistic approach to WHS in their organization. While these cases technically had safety strategies in place, their poor implementation limited the positive impact. For example, most participants had check-in systems as an official or unofficial safety strategy for call-outs and travel. However, not all workplaces had a timely follow-up if an expected check-in was missed, undermining the purpose of the strategy. A tokenistic approach to safety could also be demoralizing for the staff involved. "That is a waste of our time going to those [WHS] meetings to say, 'hey guys, this is what we've identified as a risk, just letting you know', then nothing happens" (Participant 8).

3.1.3 | Attitudes towards safety

Attitudes towards safety were spoken of as a factor that could make or break the safety strategies. "I think predominantly, staff attitudes. So if you're in a place that really valued that ['never alone'] policy, it would just be non-negotiable, and so, you'd make it work, basically" (Participant 12). Over half the participants spoke of the importance of staff being aware of the risks, and valuing and being proactive about their safety. For example, participant 14 spoke of how the clinic team discussed safety among themselves in team meetings to ensure it was a priority.

By contrast, participant 2 experienced a very "lackadaisical approach" to safety at her workplace, due to the perception that it was a safe area. Several participants highlighted the risks of complacency, especially around call-out safety, as situations can change even when one believes the situation is low risk. Several anecdotes about RANs standing up for themselves when their employers put them in unsafe situations were also discussed.

> A nurse turned up in a remote [NT region] clinic… the two nurses there go, 'oh, we're on our way out', get on the plane that person's got off, and fly off, leaving them there alone. So they ring the regional manager… and their answer is, 'oh put a [incident report] in.' [So the RAN said], 'If I don't have a satisfactory answer in the next hour… I'm going back to town at your expense.' Nurses are starting to be more proactive about their safety, which is wonderful, and just going, 'no, I won't do it'.
>
> (Participant 13)

Manager attitudes to safety also had an impact, as two RANs spoke of times when managers undermined call-out safety strategies by discouraging RANs from using a second responder. "I was up at this last community and the primary health care manager said, 'oh no, you don't need anybody to come out with you'" (Participant 4).

Attitudes to psychological safety were also an issue that several RANs felt was overlooked:

> Safety from a mental health perspective as well, is something that really doesn't get spoken about… It's assumed that burnout is part and parcel of the job, particularly if you're an agency staff member… And that… goes for on the ground… between staff, our interplay with each other, and all the way up to management. I think that that's something that there's not much structure around, and no meaningful effort to resolve.
>
> (Participant 12)

3.1.4 | Flexibility in WHS approaches

All participants were in favour of having official safety strategies in their workplace, but the majority felt that the WHS policies need enough flexibility to be adapted to the situation. Participants had different opinions on what that flexibility should look like, but most agreed it was important for improving staff safety while still enabling them to do their jobs. For example, participant 12 explained:

> I can understand why you'd develop a policy for an ideal circumstance, but… it just is not fitting reality, and I think that's really important to acknowledge. Ah, whether you have a tiered policy, where you go, 'okay this is ideal, however if you're in this circumstance, this is what you should do.' Kind of harm minimisation I guess…
>
> (Participant 12)

While several participants felt that policies which are not suited to the local circumstances are often disregarded, participant 5 did point out that "any safety guidelines are useful, in as much as they prioritise safety and keep it in the minds of staff."

3.2 | Knowledge and relationships

3.2.1 | Collaboration

Good communication and collaboration between frontline staff and managers were identified as important enablers for safety. With few exceptions, participating RANs said the clinic managers were supportive and 'get it', but that further up the chain, "much of management is dissociated. It sits in regional centres and just doesn't get it. They've either *never* worked remote or worked a *minimum* of remote or worked remote *so* long ago they've *forgotten*" (Participant 13).

Meaningful collaboration and engagement with the community were also identified as poorly implemented strategies. One participant stated "It's partnering with the community, partnering with consumers. Because I also believe consultation was so poor. So I had my own little groups, you know, elder women and the kids and teenagers" (Participant 15). Employing local community members as Aboriginal Health Workers or in non-clinical roles was also seen as an important strategy for increasing community participation in the clinic. "I think talking with local staff… whatever role they may have in the clinic, is a huge enabler of building connections" (Participant 12).

Collaboration with other service providers was another common thread that influenced staff safety. For example, participants from all regions identified collaboration with police as a significant enabler for safety, particularly for support when responding to high-risk call-outs. However, some participants found this to be a negative experience, as participant 1 explains:

> Sometimes, the police aren't very happy to come. Because they're tired, they're fatigued. We only have two police officers here and they work all day just like we do and they don't get fatigue time like we do. So, they could be up, you know, for 72 h or something or only have very little sleep.

3.2.2 | Local knowledge

All participants who had received a thorough handover and local orientation found it to be an important protective factor. Several RANs felt that building the beginnings of a rapport with community members before meeting them in a clinical setting, helped prevent workplace violence. With time, this could also develop into valuable informal support networks, though high turnover was a barrier to this, as participant 10 explains:

> The obstacle to that is the passing parade of visiting nurses and midwives. They might come once and never come again for various reasons. Then the locals don't know whether to invest their time in you or not, because they haven't had the opportunity to develop that relationship.

Many participants spoke of the benefits local Aboriginal or Torres Strait Islander staff brought to the team, especially how their local knowledge improved call-out safety. However, participant 13 pointed out that this only works "*if* the nurses will listen to [their advice]."

A lack of cultural education for RANs was also seen as a gap:

> One of the things that few health services do these days, is that they'll all identify the importance of cultural education, but like [a health service] said 'oh that happens when you get out to the community'. But it didn't. It didn't unless you took it on yourself. No one… out there was paid to sit down with you for two hours…
>
> (Participant 5)

Two senior RANs described how their understanding of the cultural norms within the community enabled them to come up with effective situational safety strategies when faced with potential incidents.

3.2.3 | Preparation/suitability for the role

For RANs to be safe and effective in their role, experience and education were considered essential, but access to training was difficult for many participants. Participant 2 stated "just the fact that you're in a remote area makes it difficult to access regular training," while others highlighted issues such as understaffing and the COVID-19 travel restrictions as barriers. However, participant 11 found that

blasé attitudes towards safety among staff could be a barrier to the uptake of safety training.

Where face-to-face training was offered, participant 12 found it to be a good opportunity to meet other RANs, share stories and learn from each other's experiences. However, the training did not always reflect the reality of the work.

> There's a lot of things that truthfully you just do, because there's nobody else to do it, or there's no facilities… I think sometimes a lot of the training that's offered is, idealised, to a context that's a lot higher resourced, and it's not applicable to a remote context.
>
> (Participant 12)

3.2.4 | Good healthcare = safer staff

Providing good emergency care was said to reduce the risk of workplace violence. Having sufficient staff, with the skills and knowledge needed for the situation, was identified as a solution by two participants.

> You can increase your vulnerability if you are at, say, [a motor vehicle accident] or a child is very sick and crashing… you can really reduce your level of safety if you cannot manage a patient. It's hard on your own, and if you have got a second set of hands who knows what they are doing, like a second nurse, it can really put a lot of people at ease.
>
> (Participant 2)

Good primary health care was also identified as a safety strategy, including improving health literacy and empowering community members to self-manage minor ailments. For example, a RAN from a small community reported that over three years, their clinic team significantly reduced the number of overnight call-outs and medical evacuations through a strong focus on primary health care.

> Instead of a medevac every 10 days and probably a half overnight [call-out] every week, it became that there was a medevac about every 16 days, 17 days, and an overnight at the clinic… twice a month.
>
> (Participant 5)

3.3 | Resources

3.3.1 | Impact of staffing

Several participants spoke of how a lack of staff created tensions between staff safety, fatigue management and keeping the clinic open. Being able to simultaneously enforce fatigue management and 'never alone' policies in small clinics was a significant challenge, especially when RANs used another nurse instead of a driver as the second responder. This led to temporary clinic closures or reductions in services to outlying communities and outstations, creating a backlog of primary healthcare recalls.

> If the person has used a nurse rather than the second responder, we are only a four-nurse clinic, and that takes out two people… Also, three days a week, we have to go to another clinic that's 40 minutes away, so that means that that clinic or that community doesn't get serviced, because there's not enough people to service it.
>
> (Participant 14)

One participant spoke of how working in a single nurse post meant she usually would not take fatigue leave, as there was no one else to open the clinic. She described how this could snowball "because if you're on call [again] that night, you don't necessarily get a rest after you do finish work… [At one clinic], there was literally nobody else: you could be on-call 17 days straight" (Participant 6). Several other RANs also spoke of the cumulative impact of fatigue, especially when there were few colleagues to share the on-call duties with.

> But that's not a policy failure. Like the fatigue 10-hour break is in there. But if you're short staffed, or you don't have a big pool to draw from… you're just working. You work days, you work on-call nights, you work weekends, and you're back during the week. So… I think it's very fatiguing.
>
> (Participant 9)

3.3.2 | Drivers

There was much discussion around what makes a good second responder, and the pros and cons of different approaches. Drivers recruited from the local community were a solution to the issue of improving call-out safety while managing RANs' fatigue. Several RANs saw having a trusted local community member as a second responder as an important safety strategy itself:

> Whereas if you've got your local driver, he can tell you, 'no don't get out in this house', or 'now watch out for her', or whatever. The local knowledge is the important thing, not the presence of two people.
>
> (Participant 13)

However, several RANs were concerned about the lack of first-aid training for drivers in most clinics, given that they are expected to accompany RANs to medical emergencies.

A major barrier was when health services had difficulties recruiting local community members as second responders in some communities. "We've tried many times to have local people [as drivers], and nobody is interested" (Participant 14). In three cases, non-Indigenous people who lived in the community were used instead, meaning those drivers did not have the clinical *or* cultural knowledge to improve staff safety during call-outs. "So there was no cultural negotiation available… she didn't know people, she had no first aid training" (Participant 2). Two participants also found that retention of drivers could be an issue if RANs frequently went on call-outs unaccompanied.

3.3.3 | Infrastructure

Clinic safety varied, with a few participants explaining that this was linked to how old the buildings were. "A lot of the clinics are so old, and they are being refurbished so they are [taking safety features] into consideration" (Participant 4). A common safety strategy discussed by participants involved preventing crowding within the clinic. Clinic design could either help or hinder this:

> If we see someone after hours – so we generally have the patient and then one other person… One of our barriers is that… in WA, to lock and unlock the door… you just turn the lock. So… if you're both busy with the patient, a family member can go to the door and open it and let more people in. In the NT it's a swipe card, so you actually can't get in and out unless you have the card…
>
> (Participant 7)

Accommodation safety was spoken of as an ongoing issue, though many RANs were unfazed by unsecure accommodation if they thought it was a safe community. For example, participant 11's accommodation was not secure, but "I never felt threatened… in the two and a half years I was out there, not one of our houses ever got broken into." Participant 12 reiterated this point, saying that accommodation security tends to be in context with the stability of the community.

Where accommodation *was* considered unsafe, it could have a significant negative impact on the RAN's mental well-being, as well as putting them physically at risk.

> The accommodation *needs* to be secure, so you can't have someone kick in a door for instance… You need it for the practical things of keeping people safe, but also, for the psychological wellbeing of the staff member. If they're in a secure building, they're more likely to sleep, they're more likely to feel less stress.
>
> (Participant 13)

Poor maintenance was a major barrier to clinic and accommodation safety. Participants acknowledged that it's difficult for health services to get repairs done quickly, due to the remoteness of their workplaces, but many felt that more could be done to improve the process, such as having routine maintenance and prompt escalation of reported faults.

> Of course, in any remote area geographically it's challenging. It's easy to get flooded in… Then all the [COVID-19] stuff. So there is still no routine, regular maintenance, and there's still this - well, it's been going on for 15 years - is people make lists of things that need doing for each clinic… It's a running joke in [Qld region] about the lists.
>
> (Participant 2)

Two other participants spoke of times when issues identified in WHS inspections were not addressed. For example, participant 3 said "We did an OHS inspection while I was there… There were leaks everywhere… So, rather than try and fix it, you know where to place the buckets and the hazard signs."

3.3.4 | Equipment

Communications technology was another key aspect of call-out safety strategies, giving community members a way to request assistance after hours without visiting the RAN's house, and enabling second responders to be contacted. "If it's out of hours, you ring your second-on-call… If it's a local driver, he may not have a mobile, so we give him a two-way radio" (Participant 10).

Clinic vehicles were not fit for purpose in several clinics in the tropics, either by not being adequate for the terrain or being poorly maintained.

> But there were no headlights working on it. It had rusted. So, I literally used to hold up one of those big torches out the front of the window, and drive along with that… I said [to the health service's manager] 'if a nurse runs a child over in the middle of the night and kills them, and you say that you knew that we had vehicles that were not working effectively, and you did nothing about it, where the hell do we stand?'
>
> (Participant de-identified due to legal implications)

Conversely, several participants reported that travel safety strategies were implemented well. These strategies were sometimes undermined by RANs forgetting to take the satellite phone or forgetting to check-in before departing, or by managers failing to follow up on a staff member who went missing. Where check-in systems were run by colleagues within the clinic or had a centralized manager who kept track of all call-outs/travel for the region, the follow-up of missed check-ins was much better. "There was always someone that noticed that you didn't come back" (Participant 7).

Duress alarms were met with mixed responses from participants. A common thread was that given the time it would take for any help to arrive in an emergency, the usefulness of duress alarms was limited. However, one participant found that a locally audible alarm could be a deterrent, and another reported that the duress alarm system worked well at her clinic. "You touch those alarm buttons and they're ringing you within two minutes" (Participant 4).

3.3.5 | Funding

Lastly, half the participants identified funding as a barrier to some safety strategies, mainly maintenance and having safe staffing levels. For example, one RAN experienced pushback from the health service's finance team while establishing a reliable pool of local drivers for the clinic. "So I got the 24-hour drivers, and in the end, I ignored finance" (Participant 15). Some health services mitigated the costs of implementing a safety strategy by renegotiating their employment model.

> Recently I know [NT ACCHO] has brought in laptops so that the person on-call has a laptop so they have access to the person's files… That is actually very useful. It has implications for the health service, because of course, as soon as you open that file, you are at work. So even if you don't attend, they have to pay you a call-out… Some of the health services are getting around that now by giving you a loading, rather than giving you a call-out fee.
>
> (Participant 13)

Several participants spoke of recent purchases of safety technologies, such as emergency GPS devices for the vehicles or security technology. "The company did come into some money a while back, and they put on security sensors on all the houses… for the staff. And there's big massive lights that are on at the clinic" (Participant 14). Participant 5 pointed out that "not all guidelines require additional resources" though, so even resource-poor health services can make an effort to improve staff safety.

In the end, a common thread in the stories shared by the RANs was that funding for safety strategies – much like their overall approaches to safety – varied greatly between health services.

> So you know in terms of safety, this health service has policies and guidelines. It has enthusiastic implementation by the manager and the staff. And it has the resources to support the guidelines. And that is very different if you're going to ask me about the community in WA and the other health service.
>
> (Participant 5)

4 | DISCUSSION

4.1 | Commitment to safety

Commitment to safety was a broad theme, but one that was an underlying essential factor for achieving safe clinics. RANs' anecdotes uncovered significant variations in approaches to WHS among the different health services and regions. Several participants expressed frustration over this variation, seeing a poor commitment to safety by some health services as a failure to meet their duty of care. Such health services seemed to not follow a 'risk management' approach to WHS, one of the key recommendations from the literature (Wright et al., 2021). As described in the *How to manage work health and safety risks Code of Practice*, the risk management process involves proactively identifying and controlling risks (Safe Work Australia., 2020).

For each RAN who shared their experience of employers striving to improve workplace safety, there was one for whom the opposite occurred. Several examples depicted employers with a resigned, 'this is just how it is' approach to risks that they were legally obligated to mitigate under the WHS National Uniform Legislation (NUL) Act and Regulations (NT, 2011a, 2011b). Examples included requiring staff to drive an unroadworthy vehicle for work, having clinics and accommodations that expose staff to significant health and safety risks (Part 2, Division 2 of the WHS (NUL) Act), and not supplying effective systems of communication for staff working in remote or isolated areas (Part 3.2, Division 6 of the WHS (NUL) Regulations). These stories indicate that legislation alone is not enough to address the issue of poor workplace safety in the remote health sector. A culture shift within the industry will be needed to achieve widespread change.

4.2 | Knowledge and relationships

Good communication and collaboration are necessary between health services, their staff, communities and other service providers. Several participants' views mirrored the findings from a previous study, where many policies and safety strategies were considered inappropriate or not feasible in the local context (McCullough, Lenthall, et al., 2012). This led to tensions between what was required by policy and what was possible (or helpful) with the existing resources. In some cases, RANs were willing to offer feedback and management were willing to review and adapt their safety strategies. These collaborative improvements created safety strategies that those participants found more feasible to implement.

Local knowledge was considered a significant protective factor for staff safety. Familiarity with people and places within the community, as well as understanding the cultural norms, helped participants keep themselves safe. Several enablers for gaining and sharing local knowledge were identified, including a good local orientation and handover, building a rapport with local community members,

utilizing the knowledge of local staff, and information sharing processes. This mirrors and builds upon the findings from previous research, where inadequate local orientation was identified as a significant risk to safety (Wright et al., 2021).

4.3 | Resources

Understaffing can mean RANs have to choose between keeping themselves safe or providing good healthcare to communities that are already disadvantaged. Staffing levels, 'never alone' policies and fatigue management were spoken of as intertwined issues, as having a second responder and managing fatigue were mutually exclusive when working with a small pool of staff unless services were reduced. A strategy for overcoming this was to use drivers recruited from the local community as second responders instead of another RAN. This had the significant added benefit of providing access to greater local knowledge on call-outs, though at the expense of clinical knowledge. Health services sponsoring drivers to undertake first aid and volunteer ambulance courses has been identified as both a recruitment incentive and a pathway for more Aboriginal and Torres Strait Islander people to enter the health profession (Aitken et al., 2021).

Infrastructure safety was also a common concern for participants. Even those with strict policies around safe work practices had issues with the maintenance of their accommodation, clinic, or vehicles. This led to ethical issues such as employees feeling compelled to break the law to carry out their work and reported WHS hazards being left unaddressed. Previous literature had also identified infrastructure safety as an issue, but except for discussing poor maintenance, only one article specified how the buildings were unsafe (CRANAplus, 2017; Fisher et al., 1995; McCullough, Williams, et al., 2012). This study identified specific strategies that RANs found effective, such as having security screens on the accommodation and self-closing and locking doors at the clinic to assist with crowd control. Good communication systems improved psychological safety by reducing feelings of isolation, and in the case of remote access to medical records, helped with risk assessments.

5 | STRENGTHS AND LIMITATIONS

There are some limitations to this study. First, this study focuses on RANs' perspectives, meaning the views of Aboriginal and Torres Strait Islander Health Practitioners, non-clinical staff, upper management and visiting health professionals were outside the scope of this study. We acknowledge the importance of these perspectives and recommend further research to explore their views.

Secondly, this study focussed only on the health sector. As many other industries and professions also work in remote areas, cross-sector collaboration and learning may also provide useful insights into future research.

Thirdly, there is great diversity and variability within the remote health sector. RANs from a wide range of regions, service types, contract types, roles and years of experience participated in this qualitative study, providing a diverse range of views. However, we acknowledge that some RANs may have different perspectives to those shared by the participants.

Lastly, while not required in reflexive thematic analysis, having more than one researcher carry out the coding could have brought another perspective to the findings.

Despite these limitations, this study is the first to our knowledge to explore RANs' experiences of the existing WHS strategies in remote clinics. By providing a platform for RANs to share their feedback around the current approaches to workplace safety, this study can help employers and policymakers to further improve those strategies. This is an essential step in continuous quality improvement. Sentinel events like the murder of RAN Gayle Woodford and the impact of poor WHS on recruitment and retention highlight the importance of WHS.

6 | CONCLUSION

In this study, RANs shared myriad experiences of the WHS strategies at their workplaces, adding rich and unique perspectives to what has been a complex and somewhat intractable problem. Poor or inconsistent WHS practices, weak policy frameworks and unenforced WHS legislation can serve to imperil the recruitment, retention and well-being of healthcare staff in remote areas. Meaningful and sustainable change will require a multi-level, multi-faceted response to create new patterns of behaviour among both employers and staff. We propose that embedding WHS performance indicators into organizational continuous quality improvement processes, promoting and rewarding a culture of WHS excellence and developing and implementing best practice benchmarks and exemplars, be consistently and transparently applied across all remote area jurisdictions. Meanwhile, WHS regulators should conduct targeted monitoring of all remote health services' compliance with existing WHS legislation, with enforcement actions taken to resolve the breaches. These strategies have implications not only for current and future RANs but for all remote health stakeholders, from patients to peak bodies. This kaleidoscope of issues offers many potentially fertile areas for further research in Australia and internationally, and we trust that the findings presented here stimulate further inquiry into this important aspect of professional practice.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

PEER REVIEW

The peer review history for this article is available at https://www.webofscience.com/api/gateway/wos/peer-review/10.1111/jan.16028.

DATA AVAILABILITY STATEMENT

Data from this project are prepared for publication (with conditional access) alongside this article, for re-use in future research about workplace health and safety in remote health. Wright (2022) future studies using this data must maintain the confidentiality of participants' information and be conducted in accordance with the National Statement on Ethical Conduct in Human Research.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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